

POLICY: 1.009 CASE CONFERENCING

Case conferencing must be performed with the patient's medical, behavioral health and/or social service provider(s) at least once every six months or following any significant or critical changes in the patient's health or social status that might impact his/her health and wellbeing. Case conferencing should occur preferably face-to-face or by phone/videoconferencing. Clearly document any exchange of information with patients and/or service providers during the case conference. As a best practice, case conferences are to involve the patient, and at minimum, at least one service provider.

What is Case Conferencing?

Case conferencing is a care management technique involving an exchange of information between the patients' care team to enhance patient's care coordination and minimize duplication of services across providers. For Health Home patients, the care team includes the Care Management Agencies (CMAs), service providers (i.e., medical, behavioral and social service providers) and Managed Care Organizations (MCOs) involved in their care. Case conferencing can include more than one service provider and the MCO and should include the patient and family/other supports as needed.

PROCEDURE:

Case Conferencing

1. Procedures must be in place for determining which patients are due for case conferencing.
2. A minimum of one case conference must be conducted with the patient's medical, behavioral health, or social service provider(s) face-to-face, by phone/videoconferencing, or email every 6 months.
3. Additional case conferencing are to be conducted following any significant or critical changes in the patient's health or wellbeing. Examples of these changes include non-adherence to medications and treatments, suicide ideation, and noncompliance with medical appointments.
4. Case conferencing are to be used to discuss the patient's health status, needs or goals. Specific topics for discussion may include:
 - a. Confirmation of a diagnosis,
 - b. Changes in patient's health status, needs, or goals,
 - c. Changes to prescribed treatment regimen(s),
 - d. Provider roles and responsibilities for specific goals/action steps listed in patient's Care Plan
 - e. Patient's progress and barriers towards meeting Care Plan goals and action steps (including conflict resolutions)
 - f. Updates to the patient's Care Plan (e.g., new referrals, new goals and/or action steps), and
 - g. Other needs for facilitating care coordination
5. If service providers do not respond to requests for case conferencing, CMAs must document this in the Care Plan Activity Note on ACD.
6. Following each case conference, verify that there is a follow-up action plan reflected in the patient's Care Plan.

Documentation

1. All case conference activities, including unsuccessful attempts, must be documented in the HH Case Conference Assessment and Care Plan Activity Note on ACD.
2. For case conferencing by modes other than face-to-face or phone/videoconferencing, very carefully and thoroughly document any exchanges in information with patients' service providers on the HH Case Conference Assessment and Care Plan Activity Note; this can include, for example, uploading copies of e-mails exchanged.